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ABSTRACT

This report provides a brief overview of state policies and programs to address the problems of adolescent pregnancy and parenting. Section 1, a brief introduction, is followed by a section which examines a broad set of state policies and programs affecting at-risk youth, including pregnant teenagers and teenage parents. The state-by-state review provided in this section covers the following specific areas: (1) state planning and coordination, including task forces, individual agency initiatives, and coordinated programs and policies; (2) health care programs and policies, including family planning services, support for school-based clinics, and Medicaid coverage of low income pregnant women; (3) educational programs and policies, including preschool child development, middle grades improvement, efforts to reduce school failure among older youth, and family life education; and (4) employment and training initiatives. The final section presents conclusions and provides a table summarizing the major types of organizational and programmatic responses of states for addressing the issues of teenage pregnancy and parenting. It is concluded that the data shows that many states have taken significant steps toward improving their health, education, and employment/training programs to more effectively meet the needs of high-risk children and youth, but that states still have a long way to go in establishing universal primary prevention programs. Appendices include information about existing data sources on the subject of adolescent pregnancy and parenting and a list of state contacts on teenage pregnancy and parenting. (NB)

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AN OVERVIEW OF STATE POLICIES AFFECTING ADOLESCENT PREGNANCY AND PARENTING

State Policy Reports

Human Resources Policy Studies

Social Services Program

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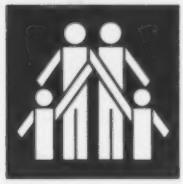

AN OVERVIEW OF STATE POLICIES AFFECTING ADOLESCENT PREGNANCY AND PARENTING

NATIONAL GOVERNORS' ASSOCIATION

State Policy Reports

Human Resources Policy Studies

Social Services Program

by Jeffrey J. Koshel

Human Resources Policy Studies
Center for Policy Research

National Governors' Association

The National Governors' Association, founded in 1908 as the National Governors' Conference, is the instrument through which the nation's Governors collectively influence the development and implementation of national policy and apply creative leadership to state issues. The association's members are the Governors of the fifty states, the commonwealths of the Northern Mariana Islands and Puerto Rico, and the territories of American Samoa, Guam, and the Virgin Islands. The association has seven standing committees on major issues: Agriculture and Rural Development; Economic Development and Technological Innovation; Energy and Environment; Human Resources; International Trade and Foreign Relations; Justice and Public Safety; and Transportation, Commerce, and Communications. Subcommittees and task forces that focus on principal concerns of the Governors operate within this framework.

The association works closely with the administration and Congress on state-federal policy issues through its offices in the Hall of the States in Washington, D.C. The association serves as a vehicle for sharing knowledge of innovative programs among the states and provides technical assistance and consultant services to Governors on a wide range of management and policy issues.

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Preface

This report provides a broad overview of state policies and programs to address the problems of adolescent pregnancy and parenting. State officials, advocates, and others outside of government may find it useful in identifying priorities for additional services to at-risk youth and teen parents.

The information presented in this report extends that provided in a 1985 report published by the National Governors' Association, *Addressing the Problem of Adolescent Pregnancy: The State of the Art and Art in the States*, by Dr. Madeleine Kimmich. Data are taken from a variety of sources and supplemented by a telephone survey of the states conducted during November and December 1988. States that reported some planning activity at the end of 1988 were contacted again in January 1990 to determine the current status of their planning efforts.

Acknowledgements

The report was researched and written by Jeffrey J. Koshel, a consultant to the National Governors' Association (NGA), with research assistance from Dr. Therese van Houten and Dr. Madeleine Kimmich. Final preparation and production was managed by Lynne Fender, director of the Social Services Program, NGA Center for Policy Research.

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Executive Summary

States have made considerable progress in implementing programs and policies to reduce the incidence of adolescent pregnancy and parenting. During the past four years, more than two-thirds of the states improved their administrative ability to coordinate programs for at-risk youth. A majority now have executive and/or legislative task forces or some other formal mechanism for developing more effective policies and programs to reduce teen pregnancy and assist teen parents. Additionally, many states have expanded their financial commitment to programs serving at-risk children and youth.

The most progress has occurred in the area of health care for pregnant adolescents. Recent federal legislation provided states with the opportunity to expand their Medicaid programs to cover all low-income pregnant women, rather than just those receiving Aid to Families with Dependent Children (AFDC). Nineteen states now provide coverage to pregnant women with incomes above 133 percent of poverty, the minimum required by federal statute. Fifteen of these extend coverage up to 185 percent of poverty, the maximum authorized by federal statute.

Education has been another area of increased attention by states. The past four years have seen a very significant increase in the number of programs aimed at preventing school failure among secondary school-aged youth. Perhaps more significantly, actions to strengthen the middle grades have been taken in approximately half of the states.

Employment/training and child care for teen parents have become more frequent state priorities. With the passage of federal legislation to encourage teen mothers on welfare to return to school or enter job training programs, and guarantee them child care during participation, these services can be expected to increase further.

Despite this progress, state officials are the first to recognize that a great deal more needs to be done, especially in the area of primary prevention, before significant reductions in teen pregnancy can be anticipated. Promising initiatives, such as quality preschool child development programs and school-based clinics, are still only available in a relatively small number of communities across the country. Clearly, much more work remains ahead.

1. Introduction

The United States has one of the highest rates of adolescent pregnancy of any developed country, about twice as high as those of Canada and England.[1] Every year, approximately 1 million American teenagers become pregnant.[2] Unlike earlier times, most of the adolescents who give birth today are unmarried. Because of the nature and magnitude of teen pregnancy, virtually every school district and state is affected.

It seems clear that the nation's comparatively high rate of teen pregnancy will not decline significantly without a concerted effort by all its social, religious, and political institutions. In the public sector, state government will continue to bear much of the responsibility for preventing adolescent pregnancy and for ameliorating the problems of adolescent parenting.

State policy questions affecting teen pregnancy and parenting include: how much financial support is provided to teen mothers on welfare; how much health care and social services are available to pregnant adolescents; and what kinds of alternative education programs and job training programs are targeted to at-risk youth in general, and to teen parents in particular. Furthermore, states have a great deal of influence over the availability of primary prevention services to at-risk children and adolescents, most notably the level of public support for programs for preschool-age children to improve educational performance, sex education, and family planning services.

This report examines a wide spectrum of state policies for at-risk children and youth rather than limiting its focus to programs specifically identified as teen pregnancy/parenting initiatives. If implemented in a coordinated manner, such policies can go a long way toward establishing a "model" state strategy for dealing with the problems of adolescent pregnancy and parenting.

The policy framework presented in the report is broad. It includes an analysis of state efforts to make the basic public health program – Medicaid – better able to serve low-income pregnant women and young children. State actions to reduce the number of school dropouts and to provide alternative educational settings for those who have already dropped out also are examined. Additionally, the report summarizes efforts made by states to develop special employment and training programs for at-risk youth, and compares states' financial commitments for primary prevention services.

Perhaps better than any other statistical measure, trends in the rate of teen pregnancy reveal society's effectiveness in preparing youth for adulthood. They reflect the adequacy of the nation's educational system in preparing disadvantaged youth for employment, and the availability of career opportunities for such youth. This is the

case because teen pregnancy trends affect and are affected by other trends in society, including infant mortality, low birthweight, school dropouts, youth unemployment, and intergenerational poverty. The rate of adolescent pregnancy also is an important social indicator of the future health of the United States and portends the burden that will be placed on its welfare, health, and social services systems.

In addition to statistics, state officials need current information on effective intervention strategies to evaluate their own approaches for dealing with teen pregnancy and parenthood. For that reason, many organizations are tracking state developments. For example, for three years the National Governors' Association has tracked state Medicaid and Maternal and Child Health innovations to serve pregnant women and their children. Over the past eighteen months, it has tracked state welfare-to-work initiatives targeted to at-risk youth, with particular attention to education services. Finally, NGA has assembled comprehensive data on state child care practices. Moreover, the National Conference of State Legislatures has assigned a staff member to stay abreast of legislative initiatives in teen pregnancy and parenting. For several years, the American Public Welfare Association has led a consortium of public interest groups working on the subject of adolescent pregnancy. In addition, the Council of Chief State School Officers (1986) and the Education Commission of the States (1987) have conducted surveys to learn about state developments in addressing the problems of pregnant and other at-risk youth, and the Children's Defense Fund has established a unit to monitor relevant developments in all states. Finally, The Alan Guttmacher Institute conducts regular state surveys to obtain information on initiatives related to sex education, family planning, and adolescent health. In virtually every case, private foundations have provided the initial financial support for developing this information base.

This report presents recent data from many of the sources identified above, supplemented with information obtained from a telephone survey of state officials. The first round of telephone interviews was conducted during November and December 1988, and a second round was conducted during January 1990. Areas of original data collection include general state actions to plan, develop, and coordinate programs; recent state efforts to provide educational opportunities to youth who are at risk of dropping out of school or who would benefit from returning to school; and special employment and training programs developed for at- risk youth, including teen parents. Those states that reported some planning activity during late 1988 were contacted again in early 1990 to learn the current status of their planning efforts.

Information about existing data sources on the subject of adolescent pregnancy and parenting is provided in Appendix A. State officials and others may be interested in learning more about specific programs than can be covered in an overview volume such as this report. For that reason, the names, addresses, and telephone numbers of people in each organization are provided along with their area(s) of expertise. A list of state contacts on teen pregnancy and parenting is provided in Appendix B to facilitate the exchange of information among state policymakers.

2. State Policy and Program Review

This report examines a broad set of state policies and programs affecting at-risk youth, including pregnant teens and teen parents. Specific areas of activity included in the state-by-state review are:

- State Planning and Coordination
  - Task force(s) or interagency planning committee(s)
  - Individual agency initiatives
  - Coordinated programs and policies
- Health Care Programs and Policies
  - Family planning services
  - Support for school-based clinics
  - Medicaid coverage of low-income pregnant women
- Educational Programs and Policies
  - Preschool child development
  - Middle grades improvements
  - Efforts to reduce school failure among older youth
  - Family life education
- Employment and Training Initiatives

In addition to the actions taken in each of these areas, a number of states report that they are planning or implementing public/private partnerships to prevent teen pregnancy. The Ounce of Prevention Fund, which is administered by the Illinois Department of Children and Family Services and the Pittway Corporation Charitable Foundation, probably is the best known and oldest effort of this type.[3] More recent public/private collaborations center around media campaigns to discourage adolescent pregnancy.

Within the context of a comprehensive strategy for dealing with teen pregnancy, perhaps the best example of how to develop an "abstinence" media campaign is provided by the state of Maryland. The Governor's Council on Adolescent Pregnancy of Maryland has launched a multimillion dollar media initiative, "Campaign For Our Children," which is aimed at youth between the ages of ten and fourteen.[4] Using mostly privately raised funds, a major public relations firm in the state prepared

3 State Policy and Program Review

thought-provoking posters and a very creative radio "spot." Posters have been distributed to all Maryland public middle and junior high schools, and the radio message is broadcast regularly on the state's two most popular stations. While a specific review of state media campaigns was beyond the scope of this report, it is clear more and more states are initiating such efforts.

State Organization

In the 1985 National Governors' Association report, *Addressing the Problem of Adolescent Pregnancy: The State of the Art and Art in the States*, states were grouped into four categories: those that had coordinated programs and policies for addressing teen pregnancy; those that had task forces examining this issue; those that had one or more agencies working independently; and those that had isolated local community efforts without significant guidance or resources provided by the state.

Table 1 provides current information on how states are organizationally structured for dealing with the problems presented by teen pregnancy and parenting. By itself, this table offers little guidance as to which states are doing the best job. For example, a state with a well-coordinated initiative that has only modest funding probably would not be as well prepared as a state that had several agencies working independently to administer programs statewide. However, it is clear that joint planning and interagency coordination are important tools in developing a comprehensive program.

In most states, the lead agency for dealing with adolescent pregnancy and parenting is the health department, though in a growing number of states, New Jersey and Ohio for example, the human services or human resources department is responsible for comprehensive program initiatives involving health, education, job training, and various counseling services.

Another potentially useful set of data is presented in Table 2. This table provides the results of the 1985 survey of state organizational responses to teen pregnancy and parenting. Taken together with the data from Table 1, observations can be made about how a particular state progressed between 1985 and 1990. Clearly, a state such as Ohio, which had uncoordinated programs in 1985 but coordinated its programs by 1990, moved in the right direction. Similarly, states such as Colorado, Connecticut, Maryland, New Mexico, New Jersey, Oregon, Washington, and Wisconsin made progress; task forces or individual agency efforts established in 1985 led to the development of well-coordinated initiatives during the ensuing four years.

An analysis of the data from Tables 1 and 2 reveals that more than two-thirds of the states made progress in how they are organized to deal with adolescent pregnancy. In addition to the states noted above, six states that previously had not provided supervision or resources to localities expanded their efforts by 1990, and three others formed task forces to plan initiatives in this area. Another eleven states took the recommendations of their task forces to implement one or more initiatives to address some aspect of the teen pregnancy/parenting problem.

The net result of these activities is that the number of states having coordinated programs and policies regarding adolescent pregnancy and parenting more than

Table 1
State Organizational Responses to Adolescent Pregnancy and Parenting, 1990

State	*Coordinated Programs and Policies*	*Individual Agency Efforts*	*Planning Task Force*	*Isolated Local Efforts*
Alabama		■	■	
Alaska				■
Arizona		■		
Arkansas		■		
California	■			
Colorado	■			
Connecticut	■			
Delaware		■		
Florida		■		
Georgia		■		
Hawaii		■	■	
Idaho			■	
Illinois	■			
Indiana		■		
Iowa		■		
Kansas		■		
Kentucky		■		
Louisiana		■		
Maine	■			
Maryland	■			
Massachusetts	■			
Michigan		■		
Minnesota		■		
Mississippi		■		
Missouri		■		
Montana		■		
Nebraska		■		
Nevada			■	
New Hampshire				■
New Jersey	■		■	
New Mexico	■			
New York	■			
North Carolina		■		
North Dakota		■		
Ohio	■			
Oklahoma		■		
Oregon	■			
Pennsylvania	■			
Rhode Island	■			
South Carolina		■		
South Dakota		■		
Tennessee		■	■	
Texas			■	
Utah		■		
Vermont		■		
Virginia	■		■	
Washington	■			
West Virginia		■	■	
Wisconsin	■			
Wyoming			■	
Total	17	27	10	2

SOURCE: Telephone survey conducted by the author, January 1990.

Table 2
State Organizational Responses to Adolescent Pregnancy and Parenting, 1985

State	*Coordinated Programs and Policies*	*Individual Agency Efforts*	*Planning Task Force*	*Isolated Local Efforts*
Alabama		■		
Alaska				■
Arizona		(■)		
Arkansas		■		
California		■		
Colorado			■	
Connecticut		■		
Delaware		■		
Florida			■	
Georgia		■		
Hawaii			(■)	
Idaho				■
Illinois	■			■
Indiana		■		
Iowa				■
Kansas		■		
Kentucky				■
Louisiana		■		
Maine	■			
Maryland			■	
Massachusetts	■			
Michigan			■	
Minnesota		■		
Mississippi			■	
Missouri				
Montana				■
Nebraska				■
Nevada				■
New Hampshire				■
New Jersey			■	
New Mexico		(■)		
New York	■			
North Carolina		■		
North Dakota		■		
Ohio		■		
Oklahoma		■		
Oregon			■	
Pennsylvania	■			
Rhode Island	■			
South Carolina		■		
South Dakota				■
Tennessee		■		
Texas			■	
Utah		■		
Vermont		■		
Virginia	■			
Washington			■	
West Virginia			■	
Wisconsin			■	
Wyoming				■
Total	7	20	12	11

NOTE: (■) = Revised classification made by the author based on the 1988 survey.

SOURCE: Telephone survey conducted by Dr. Madeleine Kimmich, June 1985.

doubled between 1985 and 1990 (from seven to seventeen), while the number of states not providing any policy guidelines or resources to local communities decreased from eleven in 1985 to only two in 1990.

A shift in organizational activities toward a more coordinated approach over the past four years should not be regarded as the only measure of progress. For example, while Michigan did not move in this direction it still managed to provide an impressive array of programs and services for teen parents.

Health

State health departments are the agencies most likely to take the lead in state adolescent pregnancy and parenting initiatives. Not surprisingly, such departments are involved in various types of family planning programs that, according to the National Council on Adolescent Sexuality, Pregnancy, and Childbearing, "are the surest strategy for pregnancy prevention."[5]

State activities in the area of health also involve the state welfare or human services agency, which almost always is responsible for administering the federal-state Medicaid program. In addition to financing the medical care of indigent pregnant women and infants, Medicaid represents the single largest source of state funding for family planning services. (The largest source of federal funds is Title X of the Public Health Services Act.)

Departments of human services also are the agencies most often chosen to administer special grant programs established by states for dealing with adolescent pregnancy. Clearly, state departments of health and human services must work closely together to meet the preventive health needs of adolescents, as well as the many other service needs of pregnant teens and teen parents.

Family Planning Services. Throughout the 1980s, The Alan Guttmacher Institute (AGI) followed program and financial trends in the provision of family planning services across states. The results of AGI's survey of public expenditures on family planning services for fiscal 1987 were published in the September/October 1988 issue of *Family Planning Perspectives*. Table 3 shows the distribution of state expenditures for family planning, excluding the 10 percent state match required under Medicaid. While Medicaid is the largest source of state funding for publicly provided family planning services, it is important to examine other state expenditures for such services that potentially could benefit adolescents who are not welfare recipients.

Although the data in Table 3 represent expenditures for family planning services for all age groups, adults as well as adolescents, the information provides some indication of the relative priority placed on such services by individual states for dealing with teen pregnancy. For example, it is interesting to observe that the state of California spends more than one-third of all the nation's "state-only" money ($27 million out of $77 million) on family planning services, while other populous states such as Florida spend little, if any, state money beyond what is necessary to "match" federal funds.

Most importantly, states have done a relatively good job of maintaining the level of support for family planning services throughout the 1980s. While federal

Table 3
Fiscal 1987 State Expenditures for Family Planning Services, Other than Medicaid ($ in thousands)

State	*Social Services Block Grant*[1]	*Maternal and Child Health Block Grant*[1]	*Other State Support*[2]	*Total*
Alabama	NR	0	1,780	1,780
Alaska	0	30	20	50
Arizona	290	620	0	910
Arkansas	30	230	320	580
California	0	U	27,000	27,000
Colorado	0	0	940	940
Connecticut	1,260	0	320	1,580
Delaware	U	0	190	190
Florida	0	0	10	10
Georgia	0	0	3,760	3,760
Hawaii	0	30	650	680
Idaho	10	40	570	620
Illinois	5,090	1,040	890	7,020
Indiana	0	900	0	900
Iowa	150	0	260	410
Kansas	0	0	60	60
KentUcky	0	850	290	1,140
LoUisiana	U	560	2,500	3,060
Maine	800	0	490	1,290
Maryland	0	690	2,590	3,280
Massachusetts	0	140	280	420
Michigan	0	730	1,650	2,380
Minnesota	0	U	1,130	1,130
Mississippi	1,500	80	250	1,830
Missouri	0	790	0	790
Montana	0	30	20	50
Nebraska	0	200	0	200
Nevada	0	0	0	0
New Hampshire	320	0	90	410
New Jersey	1,760	570	720	3,050
New Mexico	0	100	90	190
New York	0	11,300	11,900	23,200
North Carolina	1,640	300	1,610	3,550
North Dakota	U	120	0	120
Ohio	U	990	90	1,080
Oklahoma	0	390	3,650	4,040
Oregon	0	0	90	90
Pennsylvania	5,020	890	0	5,910
Rhode Island	30	0	30	60
South Carolina	0	250	3,200	3,450
South Dakota	0	140	0	140
Tennessee	2,390	740	790	3,920
Texas	12,470	5,280	2,310	20,060
Utah	U	U	0	0
Vermont	130	0	50	180
Virginia	1,000	350	1,860	3,210
Washington	0	0	2,920	2,920
West Virginia	400	780	300	1,480
Wisconsin	1,000	1,150	1,120	3,270
Wyoming	0	0	40	40

NOTE: 1. Includes federal and state funds.
2. Reflects state expenditures only.
U = Unavailable; and NR = No Response.

SOURCE: Gold and Guardado, "Public Funding of Family Planning, Sterilization, and Abortion Services, 1987," *Family Planning Perspectives* (September/October 1988).

spending, adjusted for inflation, under Title X of the Public Health Services Act declined between 1980 and 1987, federal and state spending under Medicaid, combined with state-only spending, increased in real terms.[6] Notwithstanding these efforts, maintaining the status quo in family planning expenditures is unlikely to contribute to lowering the rate of teen pregnancy in the United States, where publicly supplied services are far less available than in other developed countries.[7]

School-Based Clinics. School-based health clinics in junior and senior high schools have been gaining more and more interest across the country, as individual communities attempt to deal with the difficult problem of adolescent pregnancy. Such clinics are located in school buildings or, in some cases, on school grounds. Most often they are funded and staffed by an agency other than education, such as the health department. To gain acceptance of such clinics by adolescents and their parents, the services offered generally encompass a range of primary prevention health services, from physicals for team sports to family planning counseling. In addition, parental consent to use a school-based clinic normally is required. As a rule, contraceptives are not provided directly by the clinic; students are referred to a community health center or another source of contraceptive supplies.

As indicated in Table 4, thirteen states now provide financial support for school-based clinics. "Among public sources of funds, the states were the largest contributors and the only public funders to have increased their share since 1986."[8] Of these states, Michigan, New Jersey, and New York are the leaders in investing in such clinics. Additionally, four states provide policy guidelines, which can be helpful to local school boards in establishing school-based clinics even in the absence of funding.

Table 4
States Supporting School-Based Clinics, 1988
($ in thousands)

State	*Financial Support*	*State*	*Financial Support*
Arkansas	$50-100	New Jersey	$6,000* (PG)
Colorado	79	New York	4,100**
Connecticut	472	North Carolina	212
Georgia	44 (PG)	Oregon	535
Illinois	730	Rhode Island	100
Maine	99	Tennessee	–(PG)
Maryland	500	Washington	–(PG)
Michigan	2,000		

NOTES: * Total budget for all services provided by New Jersey centers.

** Includes funds for school-based clinics in New York elementary schools as well as for clinics in junior and senior high schools.

(PG) = Policy Guidelines.

SOURCE: Lovick and Stern, "School-Based Clinics–1988 Update," supplemented by telephone survey conducted by the author.

The New Jersey Department of Human Services has extended the school-based clinic concept to include a broad range of services that are delivered to adolescents through comprehensive service centers. In addition to health services, the New Jersey centers offer job readiness counseling and training, remedial education, and drug and alcohol counseling.[9]

New York has extended its support for school-based clinics to include elementary schools and now has over 100 such clinics, with about half in elementary schools and half in junior and senior high schools. The expected funding level for fiscal 1989 will be in excess of $5 million.[10]

A number of private foundations, notably the Robert Wood Johnson Foundation, have been important partners in assisting many communities in establishing school-based clinics. While the long-term effectiveness of school-based clinics in reducing the rate of teen pregnancy has yet to be established, the available evidence has been sufficient to prompt a growing number of states to adopt such programs.

Of course, state interest in establishing comprehensive school-based clinics goes beyond the issue of teen pregnancy. Between 75 percent and 90 percent of students' visits to school-based clinics have been for health services other than family planning assistance.[11] While the overwhelming majority of state officials interviewed for this report clearly saw school-based clinics as a promising method for addressing teen pregnancy, some viewed the restrictions placed on many of these facilities related to family planning services as seriously hampering clinics' efforts to deal with this problem. In 1988 Illinois Governor James Thompson vetoed a bill that would have prevented local communities from prescribing and dispensing contraceptives on site, much to the relief of those operating several clinics.[12]

Medicaid Coverage. As a result of the Sixth Omnibus Budget Reconciliation Act of 1986 (SOBRA-86), Congress gave states the option of expanding their Medicaid programs to cover all pregnant women and young children (i.e., those up to five years of age) living below the federal poverty level but above the state eligibility level for AFDC. This was the first time Congress authorized the states to "decouple" Medicaid eligibility from AFDC eligibility. SOBRA also gave states the ability to more rapidly enroll pregnant women under their Medicaid programs, through a provision known as "presumptive eligibility," and to drop any limitation on the amount of personal assets such women might have and still qualify for Medicaid. Presumptive eligibility, which extends temporary coverage to women while their formal Medicaid application is being reviewed, is especially helpful to health care providers since it guarantees Medicaid reimbursement for services rendered to young pregnant women, including adolescents.

Within eighteen months, thirty-three states elected to cover all poor pregnant women and infants with Medicaid.[13] In 1987 Congress gave states the further option of expanding eligibility to pregnant women and infants (under age one) living in families with incomes up to 185 percent of poverty. Last year, Congress passed legislation that requires states, by April 1, 1990, to provide Medicaid coverage to all pregnant women and children up to six years of age living in families with incomes at or below 133 percent of the poverty level.

Table 5
State Medicaid Coverage of Pregnant Women and Young Children, January 1990

State	*Coverage Above 133% of Poverty*	*Dropped Assets Test*	*Implemented Presumptive Eligibility*
Alabama		■	■
Alaska		■	
Arizona		■	
Arkansas		■	■
California	185%		
Colorado			■
Connecticut	185%	■	
Delaware		■	
Florida	150%	■	■
Georgia		■	
Hawaii	185%*	■	■
Idaho		■	■
Illinois			■
Indiana		■	■
Iowa	185%		■
Kansas	150%	■	
Kentucky		■	
Louisiana		■	■
Maine	185%	■	■
Maryland	185%	■	■
Massachusetts	185%	■	■
Michigan	185%	■	
Minnesota	185%	■	
Mississippi	185%	■	
Missouri			
Montana		■	■*
Nebraska		■	■
Nevada		■	
New Hampshire		■	
New Jersey		■	■
New Mexico		■	■
New York	185%	■	■
North Carolina	150%	■	■
North Dakota			
Ohio		■	
Oklahoma		■	
Oregon		■	
Pennsylvania		■	■
Rhode Island	185%	■	
South Carolina	185%	■	
South Dakota		■	
Tennessee		■	■
Texas			■
Utah		■	■
Vermont	185%	■	
Virginia		■	
Washington	185%	■	
West Virginia	150%	■	
Wisconsin			■
Wyoming		■	
Total	19	42	24

NOTE: * To be implemented at a future date.

SOURCE: National Governors' Association, 1990.

Data collected by the National Governors' Association on the states that have already expanded their Medicaid programs to cover pregnant women and young children above 133 percent of poverty are presented in Table 5. The data show that nineteen states have expanded eligibility to those above 133 percent of poverty. Moreover, more than three-fourths of the states have eliminated assets tests for pregnant women and children and almost half are implementing the presumptive eligibility option.

Education

Schools are attempting to reduce the high rate of adolescent pregnancy in two basic ways. First, many are providing basic instruction in responsible sexual behavior and pregnancy prevention methods to all students before they become sexually active. Second, some are making special efforts to improve the educational performance of at-risk youth.

Clearly, primary prevention has an important role in reducing unwanted pregnancies. Assisting adolescents who are doing poorly in school also may yield substantial benefits. Teens who are in danger of dropping out are likely to view unintended pregnancy in a less negative fashion than those who are succeeding in school and planning for additional education and professional careers.

State efforts to strengthen four elements of their educational systems are examined: early childhood education; programs for the middle grades (i.e., grades five through eight); secondary school programs for at-risk youth, including dropout prevention programs and alternative schools for teen parents; and family life education.

Early Childhood Education. Early childhood or preschool education "should not be equated with direct instruction in academic skills; rather it should be construed broadly, to include indirect teaching and activities that promote children's intellectual, social, and physical development."[14] Focusing on early childhood education programs as part of a comprehensive strategy for dealing with adolescent pregnancy may seem very strange to people outside the field of educational research. Yet, some compelling evidence is found in the preschool literature about strategies for improving school performance that have positive long-term impacts vis-a-vis reducing teen pregnancy. While a review of the extensive literature on early childhood education is beyond the scope of this publication, the reader may be interested in examining the results of the classic Perry Preschool Program of Ypsilanti, Michigan, and others that have been widely reported.[15]

Table 6 presents a list of those states that have implemented a program of early childhood education. Almost half of the states had such programs as of fiscal 1987. In several states, including California, Illinois, Massachusetts, New York, Ohio, South Carolina, and Texas, funding for early childhood education now exceeds $10 million per year, attesting to policymakers' firm conviction in the efficacy of early childhood education as a prevention program. (Additionally relevant, but not reflected in the tables, are the eleven states that now put state money into the federal Head Start program – Alaska, Hawaii, Maine, Massachusetts, Minnesota, New Hampshire, North Carolina, Ohio, Rhode Island, Washington, and Wisconsin.) The table also

Table 6
State Initiatives in Early Childhood Education, Fiscal 1987
(excluding Head Start)

State	*Population Served*	*Number of Children Served (nearest 100)*	*Amount of State Funds ($ in thousands)*
Alabama			
Alaska	3- and 4-year-olds*	100 (Fiscal 1987)	$200
Arizona			
Arkansas			
California	3- to 5-year-olds**	19,200	$35,500
Colorado			
Connecticut			
Delaware	4-year-olds	100	$200
Florida	3- and 4-year-olds***	3,500	$4,500
Georgia			
Hawaii			
Idaho			
Illinois	3- to 5-year-olds***	7,400 (Fiscal 1987)	$12,700
Indiana			
Iowa			
Kansas			
Kentucky	3- and 4-year-olds***	700	$1,130
Louisiana	4-year-olds***	1,300	$1,800
Maine	4-year-olds	200	
Maryland	4-year-olds***	2,800	$3,300
Massachusetts	3- to 5-year-olds**	Unk	$10,300
Michigan	4-year-olds***	Unk	$2,300
Minnesota	Parents	Unk	$8,800
Mississippi			
Missouri	Parents	Unk	$12,000
Montana			
Nebraska			
Nevada			
New Hampshire			
New Jersey	3- to 5-year-olds*	5,800+ (Fiscal 1987)	$7,900
New Mexico			
New York	3- to 4-year-olds**	12,000	$27,000 (Fiscal 1987)
North Carolina			
North Dakota			
Ohio	3- to 5-year-olds	Unk	$18,000
Oklahoma	4-year-olds	Unk	$830
Oregon	3- to 4-year-olds*	300	$1,100 (Fiscal 1988-89)
Pennsylvania	4-year-olds	3,300 (Fiscal 1987)	$1,700 (Fiscal 1987)
Rhode Island			
South Carolina	4-year-olds***	10,700	$10,900
South Dakota			
Tennessee			
Texas	4-year-olds**	54,500	$46,200
Utah			
Vermont	3- to 4-year-olds	300	$500
Virginia			
Washington	4-year-olds*	2,000	$4,700
West Virginia	3- to 4-year-olds*	200 (Fiscal 1986)	$260 (Fiscal 1986)
Wisconsin	4-year-olds	5,900	$4,300
Wyoming			

NOTES: * = Head Start eligibility criteria; ** = Low-income children; *** = At-risk children; and Unk = unknown.

SOURCE: Marx and Seligson, *The Public School Early Childhood Study: The State Survey*, 1988.

shows that two states – Minnesota and Missouri – have implemented sizable parent education programs. This also was a central component of the highly successful Perry Preschool Program. Finally, these data focus on what traditionally has been called preschool. In fact, there is a growing trend to incorporate a developmentally appropriate curriculum in many child care programs, especially child care centers. Many of these also receive state funds. For example, Hawaii's plan to install a child care center in every elementary school in the state by the end of 1990 is really a state initiative in early childhood education.

State Middle Grades Policies. Although many educators would argue that a state's first line of defense against school failure is a quality preschool child development program, another appropriate point of primary prevention is the middle grades. As stated in a recent Children's Defense Fund (CDF) publication, *Making the Middle Grades Work*, "The transition from elementary to secondary school . . . often thrusts these students into an atmosphere that diminishes the teacher-student relationship; developmental needs get neglected, and students begin to be grouped according to their perceived ability, which can set a pattern for life."[16]

Highlights of the CDF survey of state middle grades policies are presented in Table 7. The survey sought information on whether a state has separate, written middle grades policies or guidelines; requires specific middle grade credentials for teachers; has a special task force or study group on the middle grades; and supports model program development and dissemination. Taken together, the policies listed in Table 7 suggest the degree to which a state has identified the middle grades for special attention. Interestingly, about half of the states now support the development and dissemination of model programs for the middle grades.

Programs to Reduce School Failure Among Older Youth. In addition to strengthening their middle grades, many states have undertaken education initiatives to reduce dropout rates among secondary school-aged youth. Some of these programs have been targeted specifically to pregnant teens but most have been focused on at-risk youth in general. This strategy is consistent with the research indicating that as many teenage females drop out of school and later become pregnant as those who have become pregnant and then drop out.[17] States that are funding dropout prevention and/or alternative school programs are listed in Table 8 because adolescent pregnancy has been shown to be highly associated with school failure.[18] Programs funded by local communities, the federal government, and/or private foundations are not included in the listing.

A survey conducted in 1987 by the Education Commission of the States (ECS) on programs for at-risk youth was an invaluable resource in developing the information for Table 8.[19] Data from the ECS survey was updated by Dr. Therese van Houten and the author for this report.

State education initiatives have been grouped into three categories: planning activities involving task forces or interagency committees, in addition to those taking place under welfare reform efforts; demonstration projects to test new approaches for meeting the educational needs of at-risk youth at selected sites; and major programs that typically cover the entire state. It is entirely possible for some states

Table 7
State Middle Grades Policies and Activities, 1988

State	*Middle Grades Guidelines*	*Middle Grades Teaching Credentials*	*Special Task Force*	*Model Programs and Dissemination*
Alabama		■		■
Alaska				■
Arizona	■			
Arkansas		■		
California	■		■	■
Colorado		■		
Connecticut				■
Delaware			■	■
Florida	■	■	■	■
Georgia	■	■		■
Hawaii			■	
Idaho	■			
Illinois				■
Indiana	■	■		
Iowa				
Kansas		■		
Kentucky	■	■	■	
Louisiana				■
Maine			■	
Maryland			■	■
Massachusetts		■		■
Michigan	■			■
Minnesota	■	■		
Mississippi				■
Missouri		■		■
Montana	■		■	
Nebraska		■		
Nevada				
New Hampshire	■	■	■	
New Jersey				
New Mexico				
New York			■	
North Carolina		■		
North Dakota		■		
Ohio			■	
Oklahoma	■	■	■	
Oregon			■	■
Pennsylvania				■
Rhode Island		■		■
South Carolina	■	■		■
South Dakota				■
Tennessee	■		■	■
Texas				
Utah	■	■	■	
Vermont				■
Virginia	■	■	■	■
Washington				■
West Virginia	■	■	■	■
Wisconsin			■	■
Wyoming		■		■
Total	17	22	18	26

SOURCE: Children's Defense Fund, *Survey of State Policies and Programs for the Middle Grades*, 1988.

Table 8
State Efforts to Reduce School Failure Among Older Youth, January 1990

State	*Planning Activities**	*Demonstration Project(s)*	*Statewide Program(s)*
Alabama			
Alaska			
Arizona		■	
Arkansas	■		
California	■	■	■
Colorado		■	
Connecticut		■	
Delaware	■	■	
Florida	■	■	■
Georgia	■		■
Hawaii			■
Idaho			
Illinois			■
Indiana	■	■	■
Iowa			
Kansas			
Kentucky		■	
Louisiana	■		■
Maine	■	■	
Maryland	■	■	
Massachusetts	■	■	
Michigan	■	■	■
Minnesota	■	■	■
Mississippi	■		■
Missouri		■	■
Montana	■		
Nebraska			
Nevada			
New Hampshire			■
New Jersey	■		■
New Mexico		■	
New York	■	■	■
North Carolina			■
North Dakota			■
Ohio	■		■
Oklahoma		■	
Oregon			■
Pennsylvania			■
Rhode Island		■	■
South Carolina		■	
South Dakota	■		
Tennessee	■	■	■
Texas	■		■
Utah	■		■
Vermont	■		
Virginia	■	■	■
Washington	■		■
West Virginia		■	
Wisconsin			■
Wyoming	■		
Total	25	22	26

NOTE: * Education planning efforts for youth in addition to those occurring under welfare reform.

SOURCE: Rosauer, *The ECS Survey of State Initiatives for Youth At Risk – Teen Pregnancy,* 1988, updated by telephone surveys conducted by Dr. Therese van Houten during November and December 1988 and by the author in January 1990.

(i.e., California, Florida, Indiana, Michigan, Minnesota, New York, Tennessee, and Virginia) to have initiatives covering all three categories.

Half of the states currently have active planning efforts to reduce school failure among older children, not counting planning activities that are occurring as part of welfare reform programs. More than a third have implemented a demonstration project(s). Perhaps the most significant finding is that twenty-six states have developed statewide initiatives to reduce the rate of school failure among secondary school-aged youth. Furthermore, several states (i.e., California, Minnesota, New York, Ohio, and Wisconsin) have established more than one statewide dropout prevention program.

New York has implemented several programs of particular interest, including: a $39 million dropout prevention block grant program to local school districts with high dropout rates; [20] a stay in school partnership program among ten institutions of higher learning and thirty-eight school sites; [21] and a program for dropouts between the ages of eighteen and twenty to continue their education during Saturdays and evenings or during normal school hours, at regular schools or through vocational technical centers, depending on their personal situation.[22]

Another program of note has been developed by Wisconsin. The "Children at Risk" program requires each school district to develop an annual plan for serving students at risk of dropping out. The state provides between $3 million and $4 million per year to assist local school districts with curriculum modifications and alternative programs based on their plans.[23]

Family Life Education. Educational programs for addressing adolescent pregnancy involve instruction in human reproduction, family planning, and contraceptive methods. Many such programs exist across the country, under the title of sex education, family life education, or adolescent health education. While a large majority of parents seems to want the schools to provide their children with information about sexuality and human reproduction,[24] the degree to which local communities implement comprehensive sex and family life education is very uneven. In a report published in spring 1989, The Alan Guttmacher Institute presented survey findings on the availability and adequacy of sex education programs.[25]

The AGI survey found that four-fifths of the states require or support some form of sex education in local public schools. Much of the impetus for this widespread policy comes from the public health problems associated with the nation's AIDS epidemic.[26]

The AGI survey also suggests that state policy on family life education is not uniform or comprehensive. For example, while more than 90 percent of the states require or encourage AIDS education, fewer than two-thirds require or encourage the schools to teach about pregnancy prevention.[27] Nevertheless, states have dramatically increased their level of activity in this area. AGI reports that in 1988 seventeen states required sex education to be taught, up from three states (Kentucky, Maryland, and New Jersey) in 1980.[28] Table 9 summarizes the results of the AGI survey on state policy regarding the teaching of selected topics in sex education.

Table 9
State Policy on the Teaching of Sex Education and Selected Topics, June 1988

State	Sex Education	Selected Topics in Sex Education: Pregnancy Prevention	AIDS	Sexually Transmitted Diseases
Alabama	E	D	R	E
Alaska	E	E	E	E
Arizona	NP	NP	E	NP
Arkansas	R	R	R	R
California	NP	E	E	E
Colorado	E	E	E	E
Connecticut	E	NP	R	NP
Delaware	R	R	R	R
Florida	E	E	E	E
Georgia	R	E	R	R
Hawaii	R	E	R	E
Idaho	E	E	E	E
Illinois	NP	NP	R	R
Indiana	E	NP	R	E
Iowa	R	R	R	R
Kansas	R	NP	R	R
Kentucky	R	E	R	R
Louisiana	NP	E	NP	E
Maine	E	E	E	E
Maryland	R	E	R	E
Massachusetts	NP	NP	NP	NP
Michigan	E	E	R	E
Minnesota	E	E	R	E
Mississippi	NP	NP	NP	NP
Missouri	E	NP	E	E
Montana	E	E	E	E
Nebraska	E	E	E	E
Nevada	R	E	R	R
New Hampshire	E	E	R	R
New Jersey	R	NP	E	E
New Mexico	R	R	R	R
New York	E	E	R	E
North Carolina	NP	NP	R	R
North Dakota	E	NP	E	E
Ohio	E	E	R	R
Oklahoma	E	E	R	E
Oregon	E	E	R	R
Pennsylvania	E	NP	R	E
Rhode Island	R	NP	R	R
South Carolina	R	R/E	E	R
South Dakota	NR	NR	R	NR
Tennessee	E	E	R	E
Texas	NP	E	E	R
Utah	R	P	R	R
Vermont	R	R	R	R
Virginia	R	R	R	R
Washington	E	NP	R	NP
West Virginia	R	E	E	R
Wisconsin	E	E	E	E
Wyoming	NP	NP	NP	NP

NOTES: R = Required; E = Encouraged; D = Discouraged; P = Prohibited; NP = No Position; NR = No Response; and R/E = Required in grades 9-12/Encouraged in grades 7-8.

SOURCE: Kenney, Guardado, and Brown, "Sex Education and AIDS Education in the Schools: What States and Large Districts Are Doing," *Family Planning Perspectives*, (March/April 1989).

Employment and Training

With the passage of federal welfare reform legislation–the Family Support Act of 1988 (FSA)–states will be required to develop special education and employment/training programs for many, if not most, teen parents on welfare by October 1, 1990. For example, those parents below age twenty who receive AFDC benefits and do not have high school diplomas will be required to participate in some educational activity. Those with diplomas who have children aged three and older will be required to enter a job training program or some formal subsidized or unsubsidized employment. The new legislation should go a long way toward establishing a universal program of basic education/training for teen mothers on welfare and, in some instances, teen fathers of AFDC-supported children.

A number of states had effective employment and training programs for young welfare recipients before the enactment of FSA. Many of these initiatives were closely related to school dropout prevention campaigns and, in some cases, were administered by state education departments. Florida, Minnesota, and Washington were among those states with the most comprehensive programs.

Florida's "Teen Initiative" program provided case management and other services to keep pregnant adolescents in school, offering employment skills development, child care, and transportation assistance. In 1989 this program operated in fourteen counties where the school districts had well-established dropout prevention programs.[29]

Another ambitious pre-FSA employment initiative available to teen parents was the Minnesota "PATHS" program, which placed the highest priority on serving AFDC parents below age twenty-one. In 1989 PATHS spent approximately $56 million in state funds to provide case management, child care, employment and training services, and health care exclusively to AFDC parents and their children.[30]

Washington's "Family Independence Program" targeted teen welfare mothers and, in addition to providing services similar to the Florida program, offered incentive payments for working (i.e., an additional 15 percent of the mother's welfare grant for working part-time and an additional 35 percent for working full time).[31]

Table 10 lists the fifteen states that invested state funds to develop or enhance special employment and training initiatives for at-risk youth before federally mandated welfare reform became effective. These programs supplemented a variety of more traditional programs such as summer youth employment, vocational education, and job training, offering support services, case management, and in some cases, cash incentives. Again, the basic data for this table were provided by the ECS survey of states, updated by Dr. Therese van Houten for this report.

Child care is an essential service for adolescent parents who are involved in educational, job training, and employment programs. Prior to the recent round of welfare reform, fourteen states made some provision for child care for teen parents.[32] By October 1, 1990, all states must supply child care to AFDC-supported parents who are enrolled in education and/or employment training programs, as required under the Family Support Act. FSA particularly targets its education, training, employment, and child care services on young AFDC mothers under age twenty-four. Moreover,

Table 10
States Supporting Employment and Training Initiatives for At-Risk Youth Prior to Federal Welfare Reform Legislation, 1988

California	Maryland	New York
Colorado	Massachusetts	Ohio
Connecticut	Michigan	Virginia
Florida	Minnesota	Washington
Maine	New Jersey	Wisconsin

SOURCE: Rosauer, *The ECS Survey of State Initiatives for Youth At Risk—Teen Pregnancy*, 1988, updated for this report by Dr. Therese van Houten during November and December 1988.

this service must be continued for one year following termination of welfare benefits. Both provisions should significantly expand the availability of child care to adolescent parents and improve their chances of avoiding long-term welfare dependency.

3. Conclusions

States have made considerable progress in organizing their services and programs to deal with the difficult problems presented by teen pregnancy. In just over four years, the number of states with coordinated initiatives in this area has more than doubled.

Many states are moving aggressively to expand their primary health prevention and prenatal care services for adolescents. Support for school-based clinics has grown rapidly in several states, though in many cases restrictions impede their ability to provide family planning services. Nineteen states have already expanded their Medicaid coverage to include pregnant women and young children living in families above 133 percent of the federal poverty level.

Clearly, more and more states are instituting a variety of educational reforms to reduce school failure among high-risk students. About half of the states have both implemented middle grades improvements and developed programs for secondary school-aged youth. Further, over one-third of the states have established preschool education initiatives.

More than one-quarter of the states were operating employment and training programs for at-risk teens before congressional passage of the 1988 federal welfare reform legislation. With the new emphasis on reducing the long-term dependency of those on welfare, state efforts to provide improved education and employment training for adolescent mothers on welfare are likely to increase. Child care for these mothers can be expected to expand as states implement welfare reform programs. Notwithstanding these actions, additional employment and training efforts for at-risk youth are needed, particularly for male adolescents; they as much as young women are in jeopardy of becoming premature parents in the absence of expanded economic opportunities.

Table 11 summarizes the major types of organizational and programmatic responses of states for addressing the issues of teen pregnancy and parenting. The data suggest that California, Connecticut, Maryland, Michigan, New Jersey, New York, Rhode Island, Virginia, Washington, and Wisconsin have implemented the most comprehensive approaches for dealing with these issues. Other states such as Georgia, Illinois, Maine, Minnesota, Ohio, Pennsylvania, and South Carolina also are well along in establishing effective adolescent pregnancy and parenting programs.

The data clearly show that many states have taken significant steps toward improving their health, education, and employment/training programs to more effectively meet the needs of high-risk children and youth. However, the data also reveal that states still have a long way to go in establishing universal primary prevention programs (i.e., preschool child development, family planning services, and school-

Table 11
Summary of Major State Responses to Adolescent Pregnancy and Parenting

State	Coordinated Programs and Policies	Health Care Programs			Educational Programs				Employment Programs for At-Risk Youth
		Family Planning Services[1]	School-Based Clinics[2]	Medicaid Above 133%[3]	Preschool[4]	Middle Grades[5]	School Dropout[6]	Sex Education[7]	
Alabama		■				■			
Alaska						■			
Arizona									
Arkansas			■					■	
California	■	■		■	■	■	■		■
Colorado	■		■						■
Connecticut	■	■	■	■		■			■
Delaware						■		■	
Florida				■	■	■	■		■
Georgia		■	■			■	■	■	
Hawaii				■			■	■	
Idaho									
Illinois	■	■	■		■	■	■		
Indiana							■		
Iowa				■				■	
Kansas				■				■	
Kentucky		■			■			■	
Louisiana		■			■	■	■		
Maine	■	■	■	■					■
Maryland	■	■	■	■	■	■		■	■
Massachusetts	■			■	■	■			■
Michigan		■	■	■	■	■	■		■
Minnesota		■		■	■		■		■
Mississippi		■		■		■	■		
Missouri					■	■	■		
Montana									
Nebraska									
Nevada								■	
New Hampshire							■		
New Jersey	■	■	■		■		■	■	■
New Mexico	■							■	
New York	■	■	■	■	■		■		■
North Carolina		■	■	■			■		
North Dakota							■		

Table 11
Summary of Major State Responses to Adolescent Pregnancy and Parenting (continued)

State	Coordinated Programs and Policies	Health Care Programs			Educational Programs				Employment Programs for At-Risk Youth
		Family Planning Services[1]	School-Based Clinics[2]	Medicaid Above 133%[3]	Preschool[4]	Middle Grades[5]	School Dropout[6]	Sex Education[7]	
Ohio	■	■			■		■		■
Oklahoma		■							
Oregon	■		■		■	■	■		
Pennsylvania	■	■			■	■	■		
Rhode Island	■		■	■		■	■	■	
South Carolina		■		■	■	■		■	
South Dakota						■			
Tennessee		■				■	■		
Texas		■			■		■		
Utah							■	■	
Vermont				■		■		■	
Virginia	■	■				■	■	■	■
Washington	■	■		■	■	■	■		■
West Virginia		■		■		■		■	
Wisconsin	■	■			■	■	■		■
Wyoming						■			
Total	17	25	13	19	19	26	26	17	15

NOTES:
1. Block grants and other state funds for non-Medicaid family planning services total more than $1 million per year.
2. State funds school-based clinics.
3. Medicaid coverage of pregnant women and children above 133 percent of the federal poverty level.
4. State funding for preschool programs totals more than $1 million per year.
5. State funds middle grades model programs and dissemination.
6. State has statewide dropout program(s) for secondary school-aged youth.
7. Sex education is required by the state.

based clinics). During the 1990s, it will be especially important to review the progress made by states in this area.

Appendixes

Appendix A
Information and Technical Assistance on Adolescent Pregnancy and Parenting

Public Resources

National Governors' Association
444 North Capitol Street
Washington, D.C. 20001-1572

Contact: Linda Hay Crawford, (202) 624-5309

Information Available: Various reports on state initiatives in education, health, and youth employment. Names, addresses, and telephone numbers of Governors' staff responsible for human resources, education, health, etc.

Education Commission of the States
1860 Lincoln Street
Suite 300
Denver, Colorado 80295-0302

Contact: Patty Flakus-Mosqueda, (303) 830-3600

Information Available: Detailed descriptions of state projects to serve at-risk youth, based on survey conducted in late 1987.

National Conference of State Legislatures
1070 Seventeenth Street
Suite 2100
Denver, Colorado 80265

Contact: Heather Maggard, (303) 623-7800

Information Available: Brief descriptions of annual state legislative activity affecting teen pregnancy, including sex education, school-based clinics, and reproductive health.

Private Resources

Children's Defense Fund
Adolescent Pregnancy Prevention Clearinghouse
122 C Street N.W.
Washington, D.C. 20001

Contact: Karen Pittman, (202) 628-8787

Information Available: Numerous publications on the needs of, and services available to, pregnant teens and pregnant teen parents. Names, addresses, and telephone numbers of state and local officials and child advocates across the country who are concerned about adolescent pregnancy. Technical assistance also is available to public agencies and private groups that are planning a teen pregnancy initiative.

Healthy Children Program
Harvard University
Division of Health Policy, Research, and Education
641 Huntington Avenue
Boston, Massachusetts 02115

Contact: Philip J. Porter, M.D., (617) 732-1407

Information Available: Case studies of successful primary health programs, including school-based clinics. On-site technical assistance is available from Dr. Porter, upon request.

High/Scope Educational Research Foundation
600 North River Street
Ypsilanti, Michigan 48197

Contact: Lawrence Schweinhart, (313) 485-2000

Information Available: Monographs summarizing various preschool research projects. Technical assistance to state and local officials planning preschool child development projects also is available.

Share Resource Center on Teen Pregnancy Prevention
P.O. Box 2309
Rockville, Maryland 20852

Contact: Florence Lehr, (800) 537-3788

Information Available: Abstracts of published materials on a variety of teen pregnancy prevention subjects is available through searches of the SHARE bibliographic database. Fact sheets are available upon request, and custom searches also are available.

The Alan Guttmacher Institute
2010 Massachusetts Avenue N.W.
Washington, D.C. 20036

Contact: Asta Kenney, (202) 296-4012

Information Available: Extensive library of research on adolescent fertility, sexual behavior, and the effectiveness of various interventions aimed at reducing teen pregnancy. Reprints from *Family Planning Perspectives* are available, upon request. Detailed state-by-state review of fertility-related legislation, as of June 30, 1988, also is available.

The Support Center for School-Based Clinics
Center for Population Options
1025 Vermont Avenue N.W.
Suite 210
Washington, D.C. 20009

Contact: Jean Hyche-Williams, (202) 347-5700

Information Available: A directory of school-based clinics around the country as well as recent evaluations of school-based clinic operations.

Appendix B
State Liaisons for Teenage Pregnancy and Parenting

ALABAMA

Stan McDonald
Administrative Assistant for
Youth Affairs
Governor's Office
Room 219
The State House
Montgomery, Alabama 36130
(205) 261-7135

ALASKA

Katie Kelly
Director
Division of Public Health
Health and Social Services
Department
P.O. Box H
Juneau, Alaska 99811
(907) 465-3090

AMERICAN SAMOA

Esther Savusa
Assistant to the Governor
Washington Office of American
Samoa
1000 - 16th Street N.W., Suite 603
Washington, D.C. 20036
(202) 785-0550

ARIZONA

Judy Wulruff
Governor's Office for Children
1645 West Jefferson
Phoenix, Arizona 85007
(602) 542-3191

ARKANSAS

Dr. Jocelyn Elders
Director
Arkansas Department of Health
4815 West Markham Street
Little Rock, Arkansas 72201
(501) 661-2111

CALIFORNIA

Vivian Gammon
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Estimating Medicaid Eligible Pregnant Women and Children Living Below 185 Percent of Poverty: Strategies for Improving State Perinatal Programs by Paul W. Newacheck. June 1988. $15.00.

A companion document to the previous year's report, this volume projects, by state, potential eligibles under OBRA-87 in families with income below 185 percent of poverty.

Increasing Provider Participation: Strategies for Improving State Perinatal Programs by Deborah Lewis-Idema. July 1988. $15.00.

Assuring adequate provider participation has been a perennial concern for Medicaid, Maternal and Child Health, and other programs for low-income pregnant women and children. Given the recent enactment of OBRA-86 and states' enthusiastic response to the flexibility that allows broader coverage of these populations, the growing sense of a "crisis" in obstetrical care comes at a particularly inopportune time. This document describes the scope of the problem and provides new insights into strategies states are employing to expand provider participation in public perinatal programs.

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Measuring the impact of efforts to improve maternal and child health remains a critical challenge to all states implementing perinatal initiatives. This report discusses the broad range of methodological and data constraints states face when attempting to conduct program evaluations.

The Provision of Education and Other Services in State Welfare-to-Work Programs by Jose R. Figueroa and Robert A. Silvanik. September 1989. $10.00.

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1. E.F. Jones, J.D. Forrest, N. Goldman, S. Henshaw, R. Lincoln, J.I. Rosoff, C.F. Westoff, and D. Wulf, "Teenage Pregnancy in Developed Countries: Determinants and Policy Implications," *Family Planning Perspectives*, vol. 17, no.2 (March/April 1985), p. 55.
2. Cheryl D. Hayes, *Risking the Future: Adolescent Sexuality, Pregnancy, and Childbearing* (Washington, D.C.: National Research Council, National Academy Press, 1987), Table 2-11.
3. The Ounce of Prevention Fund was established in 1982 with matching grants of $400,000 each from the Illinois Department of Children and Family Services and the Pittway Corporation Charitable Trust.
4. Information on the Maryland "Campaign for Our Children" can be obtained from Bronwyn Mayden, Executive Director, Governor's Council on Adolescent Pregnancy, 311 West Saratoga Street, Baltimore, Md. 21201, (301) 333-0270.
5. Hayes, p. 4.
6. Rachel Benson Gold and Sandra Guardado, "Public Funding for Family Planning, Sterilization, and Abortion Services, 1987," *Family Planning Perspectives*, vol. 20, no. 5 (September/October 1988), Figure 1.
7. Jones et al., pp. 58-59.
8. S.R. Lovick and R.F. Stern, "School-Based Clinics – 1988 Update" (Houston, Texas: The Support Center for School-Based Clinics, 1988), p. 7.
9. Information about this program can be obtained from Edward Tetleman, Assistant Commissioner, New Jersey Department of Human Services, CN 700, Trenton, N.J. 08625, (609) 292-1617.
10. Information about this program can be obtained from Suzanne Z. Sennett, New York Council on Children, Mayor Erastus Corning Building, 2nd Tower, 28th Floor, Empire State Plaza, Albany, N.Y. 12223, (518) 474-6293.
11. J.G. Dryfoos, "School-Based Health Clinics: Three Years of Experience," *Family Planning Perspectives*, vol. 20, no. 4 (July/August 1988), p. 194.
12. Lovick and Stern, p. 12.
13. Ian T. Hill, *Reaching Women Who Need Prenatal Care* (Washington, D.C.: National Governors' Association, 1988), p. 9.
14. L.J. Schweinhart, *The Preschool Challenge* (Ypsilanti, Mich.: High/Scope Educational Research Foundation, 1985), p. 10.
15. For a review of the preschool literature see I. Lazar, R. Darlington, H. Murray, J. Royce, and A. Snipper, "Lasting Effects of Early Education," *Monographs of the Society for Research in Child Development*, vol. 47, no. 1-2, serial no. 194.
16. Children's Defense Fund, *Making the Middle Grades Work* (Washington, D.C.: Children's Defense Fund, 1988), p. 3.
17. Hayes, p. 126.
18. Hayes, p. 243.
19. Information about the ECS survey and its results can be obtained from Patty Flakus-Mosqueda, Education Commission of the States, 1860 Lincoln Street, Suite 300, Denver, Colo., 80295-0302, (303) 830-3600.

20. Information about this program can be obtained from Margretta Reid Fairweather, Director, Division of Child Development, New York State Department of Education, Room 362 EBA, Albany, N.Y. 12234, (518) 474-5807.

21. Information about this program can be obtained from Charles Graber, Chief, Bureau of Grants Administration, Office of Higher Education Services, Cultural Education Center, Room 5b68, Empire State Plaza, Albany, N.Y. 12230, (518) 474-5705.

22. Information about this program can be obtained from Russell Kratz, Bureau of Adult and Continuing Education Development, New York State Department of Education, EBA, Albany, New York 12234, (518) 474-4803.

23. Information about this program can be obtained from Dennis Van Den Haven, Department of Public Instruction, 125 South Webster Street, P.O. Box 7841, Madison, Wisc. 53707, (608) 266-1723.

24. Hayes, p. 143.

25. A.M. Kenney, S. Guardado, and L. Brown, "Sex Education and AIDS Education in the Schools: What States and Large School Districts Are Doing," *Family Planning Perspectives*, vol. 21, no. 2 (March/April 1989), pp. 56-64.

26. Kenney, Guardado, and Brown, p. 58.

27. Kenney, Guardado, and Brown, p. 58.

28. Kenney, Guardado, and Brown, p. 58.

29. Information about this program can be obtained from Jim Clark or Lonna Cichon, Office of Employment and Training, Department of Health and Rehabilitative Services, 1317 Winewood Boulevard, Tallahassee, Fla. 32399-0700, (904) 487-2380.

30. Information about this program can be obtained from Chuck Johnson, Welfare Reform Program, Office of Jobs Policy, Department of Human Services, 444 Lafayette Road, St. Paul, Minn. 55155, (612) 296-2266.

31. Information about this program can be obtained from Chris Webster, Family Independence Program, P.O. Box 9013, M.S. HH-11, Olympia, Wash. 98507, (206) 438-4513.

32. According to a telephone survey conducted by the author and information contained in the Children's Defense Fund publication, *State Child Care Fact Book*, the following states provided child care to teen parents in 1988: California, Connecticut, Florida, Maine, Maryland, Massachusetts, Michigan, New York, Pennsylvania, Rhode Island, Texas, and Wisconsin.

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